

**WISCONSIN MEDICAID
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)
FOR NONSEDATING ANTIHISTAMINE DRUGS COMPLETION INSTRUCTIONS**

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients. Although these instructions refer to Medicaid recipients, all information applies to BadgerCare recipients and SeniorCare participants.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form. Refer to the Pharmacy Handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid, BadgerCare, or SeniorCare to make a reasonable judgment about the case.

Prescribers are required to complete and sign the Prior Authorization/Preferred Drug List (PA/PDL) for Nonsedating Antihistamine Drugs form, HCF 11082. Dispensing providers (e.g., pharmacies, dispensing physicians, federally qualified health centers, blood banks) are required to use the PA/PDL for Nonsedating Antihistamine Drugs to request PA using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or to submit a paper PA request. Prescribers and dispensing providers are required to retain a completed copy of the form.

Providers may submit PA/PDL requests in one of the following ways:

- 1) For STAT-PA requests, dispensing providers should call (800) 947-1197 or (608) 221-2096.
- 2) For paper PA requests, dispensing providers may fax to Wisconsin Medicaid at (608) 221-8616.
- 3) For paper PA requests by mail, dispensing providers should submit a Prior Authorization Request Form (PA/RF) and a PA/PDL for Nonsedating Antihistamine Drugs to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient

Enter the recipient's last name, followed by his or her first name and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Date of Birth — Recipient

Enter the recipient's date of birth in MM/DD/YYYY format (e.g., September 8, 1996, would be 09/08/1996).

Element 3 — Recipient Medicaid Identification Number

Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

SECTION II — PRESCRIPTION INFORMATION

Element 4 — Drug Name

Enter the drug name.

Element 5 — Strength

Enter the strength of the drug listed in Element 4.

Element 6 — Date Prescription Written

Enter the date the prescription was written.

Element 7 — Directions for Use

Enter the directions for use of the drug.

Element 8 — Diagnosis — Primary Code and / or Description

Enter the appropriate *International Classification of Diseases, Ninth Edition, Clinical Modification* (ICD-9-CM) diagnosis code and/or description most relevant to the drug requested. The ICD-9-CM diagnosis code must match the ICD-9-CM description.

Element 9 — Name — Prescriber

Enter the name of the prescriber.

Element 10 — Drug Enforcement Agency Number

Enter the nine-character Drug Enforcement Agency (DEA) number of the prescribing provider. This number must be two alpha characters followed by seven numeric characters. If the DEA number cannot be obtained or the prescriber does not have a DEA number, use one of the following default codes:

XX5555555 — Prescriber's DEA number cannot be obtained.

XX9999991 — Prescriber does not have a DEA number.

These default codes must *not* be used for prescriptions for controlled substances.

Element 11 — Address — Prescriber

Enter the complete address of the prescriber's practice location, including the street, city, state, and zip code.

Element 12 — Telephone Number — Prescriber

Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the prescriber.

SECTION III — CLINICAL INFORMATION

Include diagnostic and clinical information explaining the need for the product requested. In Elements 13 and 14, check "yes" to all that apply.

Element 13

Check the appropriate box to indicate if the recipient has experienced a treatment failure or had an adverse reaction to loratadine or loratadine products with pseudoephedrine. If "yes" is checked, indicate the failed drug(s) or adverse reaction that is attributed to loratadine or loratadine products with pseudoephedrine and the dates the drug(s) was taken.

Element 14

Check the appropriate box to indicate if the recipient is a child between six months and two years of age.

Element 15 — Signature — Prescriber

The prescriber is required to complete and sign this form.

Element 16 — Date Signed

Enter the month, day, and year the PA/PDL for Nonsedating Antihistamine Drugs was signed (in MM/DD/YYYY format).

SECTION IV — FOR DISPENSING PROVIDERS USING STAT-PA

Element 17 — National Drug Code

Enter the appropriate 11-digit National Drug Code (NDC) code for each drug.

Element 18 — Days' Supply Requested

Enter the requested days' supply.

Element 19 — Wisconsin Medicaid Provider Identification Number

Enter the provider's eight-digit Wisconsin Medicaid provider identification number.

Element 20 — Date of Service

Enter the requested first date of service (DOS) for the drug. For STAT-PA requests, the DOS may be up to 31 days in the future or up to fourteen days in the past.

Element 21 — Place of Service

Enter the appropriate National Council for Prescription Drug Programs (NCPDP) patient location code designating where the requested item would be dispensed.

Code	Description
00	Not specified
01	Home
04	Long Term/Extended care
07	Skilled Care Facility
10	Outpatient

Element 22 — Assigned Prior Authorization Number

Record the seven-digit PA number assigned by the STAT-PA system.

Element 23 — Grant Date

Record the date the PA was approved by the STAT-PA system.

Element 24 — Expiration Date

Record the date the PA expires as assigned by the STAT-PA system.

Element 25 — Number of Days Approved

Record the number of days for which the STAT-PA request was approved by the STAT-PA system.

SECTION V — ADDITIONAL INFORMATION

Element 26

Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may also be included here.